STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155779	A. BUILDING 00 B. WING	08/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BOULEVARD EA NOBLESVILLE, IN46060

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F0000	This visit was for a Recertification and State Licensure survey. This visit was in conjunction with a Post Survey Revisit (PSR) to the investigation of Complaint IN00091241 completed on 6/8/11. Survey dates: August 1, 2, 3, 4, and 5, 2011 Facility number: 012305 Provider number: 155779 AIM number: 200987990 Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Heather Lay, R.N. Census bed type: SNF--52 SNF/NF--8 Residential--51 Total--111 Census payor type: Medicare--18 Other--93 Total--111 Sample: 15	F0000	Prairie Lakes Health Campus submits this plan of correction in response to the state requirement deficiencies cited during the Recertification and State Licensure Survey conducted on August 5, 2011 **Please accept this plan of correction as the providers letter of credible allegation of compliance effective September 4, 2011.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Residential sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 8/12/11 by Suzanne Williams, RN			
F0167 SS=C	A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation and interview, the facility failed to post a sign in 2 of 2 facility buildings indicating where the results of the most current annual survey and any subsequent surveys were located, for 6 of 6 residents interviewed during the group meeting (#200, 201, 202, 203, 204, and 205). This had the potential to affect 52 of 52 residents in certified skilled beds in the Main skilled health care building, and 8 of 8 residents in dually certified beds in the Legacy building of the facility. Findings include: The environmental tour was completed on 8/2/11 at 10 A.M., with the Director of Plant Operations and the Director of	F0167	**F 0167It is the practice of this provider to make the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect readily available for our residents to examine. However, in response to the findings of the 2567, the following measures and corrective actions have been taken: Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** A sign will be posted in the main skilled health care campus and in the Legacy campus indicating where the results of the most current annual survey and any subsequent surveys are	09/04/2011

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	Environmental Services in attendance. The survey book was located in the front lobby in the Main health care building, laying flat on the second self of a table. The front of the binder indicated it was the "Survey" book. A sign indicating where the results of most recent survey could be found was not posted in either the Legacy or the main building. During the group interview on 8/2/11 at 3:30 P.M., 6 of 6 residents (#200, 201, 202, 203, 204, and 205) indicated that they did not know where the survey results could be found. 3.1-3(b)(1)		located.**Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents living in the health campus and the Legacy campus have the potential to be affected by this alleged deficient practice.**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** During the next resident counsel meeting, the location of where they can view the survey results will be reviewed with the residents in attendance. A sign will be posted in the main skilled health care campus and in the Legacy campus indicating where the results of the most current annual survey and any subsequent surveys are located.**How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The ED or designee will observe that the sign posting for the location of the survey results remains in place. This audit will occur monthly times 6 months to ensure compliance. The audits will then be conducted randomly as need thereafter. The results of the audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter.	

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure that blood pressure and heart rate vital sign measurements were obtained prior to administering medications that had physician orders for specific "Hold" parameters, for 2 of 2 residents who had such orders; in a sample of 15 residents reviewed. [Resident #9 and #59] Findings include: 1. The clinical record for Resident #9 was reviewed on 8/4/11 at 12:27 P.M. Diagnoses included, but were not limited to, history of persistent nose bleed, anemia, history of transient ischemic attacks, chronic kidney disease, and hypertension. On 2/10/11, following an acute care hospitalization for a persistent nose bleed, the physician wrote an order for Amlodipine Besylate [Norvasc--a medication to treat hypertension and angina], 2.5 mg. [milligrams] daily for hypertension--"*Hold for SBP [systolic blood pressure] less than 110*." The medication was scheduled to be given "after arising" in the morning.	F0282	F 282 It is the practice of this provider for the services provided or arranged by the facility to be provided by qualified persons in accordance with each resident's written plan of care. However, in response to the findings of the 2567, the following measures and corrective actions have been taken: Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #9 and #59 Medication Administration Records (MAR) reviewed for the past 7 days to ensure Blood Pressure and heart rate vital measurements are obtained and recorded on MAR prior to administering medications that have hold parameters. If blood pressure and / or heart rate were not obtained and recorded, the resident's MD will be notified that hold parameters were not followed. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: The MARs of residents who have hold parameter orders for medications will be reviewed for the past 7 days to ensure vital measurements have been obtained and recorded on MAR. If vital measurements were not obtained and recorded, the	09/04/2011

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	The April, May, June, and July, 2011 Medication Administration Record [M.A.R.] forms all listed the order for the Amlodipine Besylate and included the "Hold" parameters. All days for each month were initialed by a licensed nurse, indicating the medication had been administered. There was no documentation on the M.A.R.s that a blood pressure had been checked prior to the administration, in order to determine if the resident's systolic blood pressure was greater than the "Hold" parameter. In an interview on 8/4/11 at 1:20 P.M., R.N. #17 indicated this was her first day on this unit and had administered the resident's medication that morning. She indicated she had taken the resident's blood pressure prior to the administration, but documented on the reverse side of the M.A.R. because there was not enough room on the front. As she pointed to the entry on the M.A.R., she indicated she did not know where blood pressure measurements would have been documented for the previous 3 days of August. In an interview on 8/4/11 at 1:25 P.M., L.P.N. #6 indicated blood pressures were obtained daily as part of the Medicare charting, and would be documented on the		resident's MD will be notified that hold parameters were not followed. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nurses will be re-educated on the campus guideline for Specific Medication Administration Procedure. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS or designee will audit MAR of all residents with orders for vital measurements and hold parameters prior to medication administration to ensue documentation is in place per the following schedule: 3 times per week times 4 weeks, then monthly times 5 months to ensure compliance. The audits will then be conducted randomly as needed thereafter. The results of the audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter.	

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	"Medicare" sheets. As she reviewed the Medicare sheets in the resident's chart, she indicated the time the blood pressures were actually taken was not, in fact, documented. The sheets indicated the shift only [i.e. "7-3"]. All of the Medicare "Skilled Nursing Assessment and Data Collection" forms that were in the resident's clinical record were reviewed, and had the following information: 5/26/11 at 5:10 P.M.--blood pressure 118/75 5/27/11 at 9:00 P.M.--blood pressure 125/85 5/30/11 at 8:00 A.M.--blood pressure 121/80 6/1/11, 7-3 shift--no blood pressure documented 6/2/11, 7-3 shift--no blood pressure documented 6/3/11, 7-3 shift--blood pressure 97/61 [no specific time actually taken] 6/10/11, "Evening"--blood pressure 99/66 6/15/11, 7-3 shift--no blood pressure documented 6/17/11, 7-3 shift--no blood pressure documented 6/24/11, 7-3 shift--blood pressure 105/57 [no specific time actually taken] 7/6/11, 7-3 shift--no blood pressure documented.			

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During the daily conference on 8/4/11 at 2:45 P.M., the Director of Nursing was given the opportunity to submit any additional documentation demonstrating that blood pressure measurements had been done prior to the administration of the medication for Resident #9.

At the final exit on 8/5/11 at 4:15 P.M., no additional evidence was provided for review related to blood pressure measurements prior to the administration of the medication, in order to determine if the medication should be held.

2. The clinical record for Resident #59 was reviewed on 8/3/11 at 2:20 P.M. Diagnoses included, but were not limited to, senile dementia--Alzheimer's type, non-insulin dependent diabetes, hypothyroidism, and hypertension.

On 5/23/11, the attending physician wrote an order for Metoprolol Succinate [a medication to treat hypertension and angina] 25 mg. [milligrams]--"give 3 tablets (75 mg.) orally once daily for hypertension. *Hold for SBP [systolic blood pressure] less than 120 or HR [heart rate] less than 60*."

The June, 2011 M.A.R. [Medication Administration Record] indicated the

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	medication had been given daily for each day of the month. Blood pressure measurements were recorded for 6/12 through 6/18, 6/20, 6/21, and 6/23 through 6/30/11. The July, 2011 M.A.R. indicated the medication had been administered each day of the month. There were no blood pressure measurements documented on the form. In an interview on 8/4/11 at 2:25 P.M., R.N. #14 indicated blood pressures were supposed to be taken and documented daily prior to administering the blood pressure medication. She indicated the blood pressure measurement should be written on the M.A.R. in a block identified as "B/P." As she reviewed the current August, 2011 M.A.R., which had no blood pressure measurements documented for August, the nurse stated, "I'll have to add that." During the daily conference on 8/4/11 at 2:45 P.M., the Director of Nursing was given the opportunity to submit any additional documentation demonstrating that blood pressure measurements had been done prior to the administration of the medication for Resident #59. At the final exit on 8/5/11 at 4:15 P.M.,			

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	no additional evidence was provided for review related to blood pressure measurements prior to the administration of the medication, in order to determine if the medication should be held. 3.1-35(g)(2)			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to implement the correct inflation level of a low-air loss specialty mattress to provide the most effective pressure-relief, for 2 of 2 residents who had a specialty mattress installed as an intervention for pressure sores, of 4 residents reviewed who used a specialty mattress; in a sample of 15 residents. [Residents #2 and #27] Findings include: 1. The clinical record for Resident #27	F0314	**F 0314 It is the practice of this provider to ensure that a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. However, in response to the findings of the 2567, the following measures and corrective actions have been taken:** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:**	09/04/2011

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	was reviewed on 8/2/11 at 10:30 A.M. The resident was admitted to the facility 8/29/10 on Hospice services. Diagnoses included, but were not limited to, dementia, anorexia with weight loss, anemia, diffuse pain, osteoporosis with history of a fractured left hip with a surgical fixation, and urinary incontinence. A "Pressure Ulcer Timeline," provided by the Divisional Clinical Support Registered Nurse, indicated the resident was admitted with orders for a low-air loss mattress with bolsters. The resident experienced a recurrent Stage I and Stage II pressure ulcer of the coccyx from 9/15/10 to 7/25/11, which healed and reopened. Multiple nutritional, treatment, and preventative interventions were implemented during this period. On 7/25/11, the coccyx area was identified as "Unstageable," which healed to a Stage II after 1 week. The use of the low-air loss bed continued from 8/29/10 through the date of the survey. On 8/2/11 at 10:20 A.M., the resident was observed lying in bed. The mattress inflation unit was positioned on the footboard at the end of the bed. The switch to control the inflation level was not marked with actual numbers, but had 9 thick "dashes" in a circle. The knob was		Resident #2 and #27 inflation settings checked using the hand check procedure outlined in the operation manual / manufacture's guideline for each low air loss mattress. Settings adjusted to ensure the 1 – 1 ½ " space range was obtained. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Resident #2, #27 and a new admission are the only resident's currently on a low air loss mattress. The new admission inflation settings checked by the provider representative (Genesis Medical) to ensure the inflation settings are correct for this resident. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Nursing staff will be educated on the hand check procedure outlined in the operation manual / manufacture's guideline for each air loss mattress and how to adjust the settings to ensure the correct inflation settings are in place. For each resident on a low air loss mattress, the nurse will document on the Medication Administration Record (MAR) that the inflation settings were checked using the hand check	

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	observed to be set on the 6th dash. There were no instructions on the motor unit to indicate the level of inflation needed to provide the most effective pressure-reducing benefits for this resident. On 8/2/11 at 1:50 P.M., the resident was observed in bed after being transferred from a geri-chair. The mattress inflation level remained on the 6th dash mark. On 8/3/11 at 10:53 A.M., the resident was observed in bed. The knob on the inflation motor unit was positioned between the 7th and 8th dash mark. On 8/4/11 at 9:50 A.M., the resident was observed in bed. The knob on the inflation motor unit was positioned between the 7th and 8th dash mark. Information related to the inflation level for the most effective pressure relief was not found in facility or Hospice documentation, progress notes, C.N.A. assignment sheets, or Care Plans. In an interview during the daily conference on 8/3/11 at 3:45 P.M., the Divisional Clinical Support Registered Nurse indicated the resident's mattress was provided by a durable equipment supplier through the Hospice agency, and		procedure and that suitable pressure is intact, every shift. The use of the hand check procedure for checking suitable inflation levels for the low air loss mattress will be added to the resident's plan of care interventions. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur**: DHS or designee will audit the inflation settings using the hand check procedure, MAR documentation and careplan for all resident's on a low air loss mattress to ensure settings are appropriate and documentation is in place per the following schedule: 3 times per week times 4 weeks, then monthly times 5 months to ensure compliance. The audits will then be conducted randomly as needed thereafter. The results of the audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter.	

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	Hospice was responsible for maintaining the mattress. 2. In an interview during the initial orientation tour on 8/1/11 at 11:00 A.M., L.P.N. #6 indicated that Resident #2 was on a "low air-loss" mattress for a Stage IV pressure sore. On 8/3/2011 at 9:10 a.m., the resident's low air-loss mattress inflation was observed to be set at the "soft" level. The clinical record for Resident #2 was reviewed on 8/2/11 at 10:50 A.M. Diagnoses included, but were not limited to, rheumatoid arthritis, osteoporosis, history of urinary tract and bowel infections, and pressure sore. On 8/4/11 at 11:00 A.M., the Divisional Clinical Support Registered Nurse provided a "Pressure Sore Timeline." The timeline indicated the resident had multiple admissions to an acute care hospital between 6/25/10 and 4/29/11 for multiple chronic health problems. On 4/29/11 the resident was readmitted to the facility with a Stage II pressure sore. Nutritional, treatment, and preventative interventions were implemented following the residents readmission, including a "pressure reducing mattress." On 6/15/11, the mattress was changed to a low air loss mattress.			

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Information related to the inflation level for the most effective pressure relief was not found in facility progress notes, or on the C.N.A. assignment sheet or Care Plan.

In an interview on 8/3/2011 at 9:45 a.m., L.P.N. #6 indicated that staff did not change the settings for low-air loss mattresses, and there was no particular, documented setting for Resident #2's mattress. L.P.N. #6 indicated that someone from the company that provided the specialty mattress came in twice monthly to check the mattress, and would come at any time if facility needed assistance. L.P.N. #6 indicated the facility did not have a policy or procedure for Resident #2's "low air-loss" mattress; however, if there were any questions regarding the mattress, the surveyors could call the company.

3. On 8/4/11, the Divisional Clinical Support Registered Nurse provided a copy of the Manufacturer's manual for the "Ultra-Care" low-air loss mattress utilized by Resident #2 and #27. The manual included, but was not limited to, the following information:

"GENERAL: The Ultra-Care series is a high quality and affordable air support surface suitable for medium and high-risk

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	pressure ulcer treatment.... INTENDED USE: The Ultra-Care series is intended to reduce the incidence of pressure ulcers while optimizing patient comfort.... OPERATION: ... Hand check: Check to see if a suitable pressure is selected by sliding one hand below the air mattress and the foam base (or bed frame if there is no foam base) and feel the patient's buttock. Users should be able to feel the space in between, and the acceptable range is approximately 25 to 40 mm. [millimeters] (1 inch to 1 1/2 inch).... Turn the pressure-selector knob to adjust the pressure from the soft to firm position according to patient's weight and comfort.... For suitable pressure, please refer to page 10 for the hand check procedure...." 3.1-40(a)(2)			
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and	F0315	**F 315**	09/04/2011

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	155779	A. BUILDING 00 B. WING	08/05/2011

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	record review, the facility failed to provide a comprehensive assessment to demonstrate that 1 of 1 residents, who recently had an indwelling catheter anchored, had a clinical condition that justified the use of a catheter; in a sample of 15 residents reviewed. [Resident #27] Findings include: The clinical record for Resident #27 was reviewed on 8/2/11 at 10:30 A.M. The resident was admitted to the facility 8/29/10 on Hospice services. Diagnoses included, but were not limited to, dementia, anorexia with weight loss, anemia, diffuse pain, osteoporosis with history of a fractured left hip with a surgical fixation, and urinary incontinence. A "Pressure Ulcer Timeline," provided by the Divisional Clinical Support Registered Nurse, indicated the resident experienced a recurrent Stage I and Stage II pressure ulcer of the coccyx from 9/15/10 to 7/25/11, which healed and reopened. Multiple nutritional, treatment, and preventative interventions were implemented during this period. On 7/25/11, the coccyx area was identified as "Unstageable," which healed to a Stage II after 1 week.		**It is the practice of this provider to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. However, in response to the findings of the 2567, the following measures and corrective actions have been taken:** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #27 elimination circumstance and reassessment form (comprehensive assessment) dated 7/31/11 will be updated to include reason for catheter insertion related to wound. This clinical condition is also listed on the MD order dated 7/31/11 for catheter insertion. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Will complete audit of elimination circumstance and reassessment form (comprehensive assessment) for all residents who have a catheter to ensure a clinical condition to justify the use of the catheter is documented. If	

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	On 8/3/11 at 11:00 A.M., the resident's coccyx area was observed when L.P.N. #4 and Q.M.A. #5 performed a dressing change treatment. The coccyx was observed to have a large area of intact discolored skin surrounding a 2-inch open area of top dermis-layer depth. The 2-inch open area surrounded a 1/2 inch round, deep [to subcutaneous tissue depth] open area. The resident was observed to sleep through the dressing change process, which lasted 30 minutes. She did not display any signs of discomfort during the dressing change. An annual M.D.S. [Minimum Data Set] assessment, with an Assessment Reference Date of 7/19/11 and completed on 8/2/11, indicated the resident was incontinent of bowel and bladder, and did not have a catheter. On 7/31/11, the attending physician gave an order for "May place Foley catheter--comfort/wound." A comprehensive assessment, completed prior to anchoring the catheter and to demonstrate that the resident had a clinical condition to justify the use of a catheter, was not found.		lack of documentation is noted, the elimination circumstance and reassessment form will be updated. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The DHS or designee will re-educate licensed nurses on the campus guidelines for completion of the circumstance and reassessment forms (comprehensive assessments). **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Per the campus guidelines, the interdisciplinary team (IDT) will review the initiated elimination circumstance and reassessment form (comprehensive assessment) in the daily clinical meeting 5 days a week, ongoing. The review is to ensure the thoroughness of the assessment is in place and that it is complete and accurate based on the clinical condition justification for catheter insertion. Additional information or changes noted will be made on the elimination circumstance and reassessment form during the IDT review. The results of the audit/review will be reported, reviewed and trended for compliance thru the campus Quality Assurance	

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	During the daily conference on 8/4/11 at 2:45 P.M., the Director of Nursing was given the opportunity to submit any documentation of an assessment for the use of the catheter. On 8/5/11 at 10:00 A.M., the Divisional Clinical Support Registered Nurse provided a copy of the "Elimination Circumstance, Reassessment and Intervention" form, which was dated 7/31/11. The form included, but was not limited to, the following information: "Circumstance: catheter insertion. Contributing factors: ... Other: comfort Elimination Risk Re-assessment: ... Does the resident have intractable pain?--No; Does the resident have a diagnosis that contributes to the use of a catheter?--Yes [a diagnosis was not documented]...." There was no other information on the form that related to the reason the resident required a catheter, or the clinical condition that justified its use. In an interview on 8/5/11 at 10:00 A.M., the Divisional Clinical Support Registered Nurse indicated the physician had written the order for the catheter for "comfort/wound."		Committee for a minimum of 6 months then randomly thereafter.	

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	3.1-41(a)(1)			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview, observation and record review, the facility failed to provide adequate supervision in the bathroom for a resident who was identified as high fall risk, had a history of falls prior to admission, and had multiple falls in the bathroom in the facility after admission. The resident sustained a fractured hip and wrist in each of two falls in the bathroom. This deficient practice impacted 1 of 6 residents reviewed who had a history of falls in the facility, in a sample of 15 residents. [Resident #2] Findings include: On 8/1/11 at 11:00 A.M., a tour of the facility was completed with the Director of Nursing and L.P.N. #6. In an interview at that time, L.P.N. #6 indicated Resident #2 had a history of frequent falls within the facility. On 8/2/11 at 2:45 P.M., Resident #2 was observed while being transferred from	F0323	**F 323It is the practice of this provider to ensure that the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. However, in response to the findings of the 2567, the following measures and corrective actions have been taken: Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #2 careplan updated to include staff to be present with resident when she is in the bathroom or bathroom door to be left slightly open when resident is in bathroom so staff can provide adequate supervision. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Review of falls in bathroom for past 30 days for current residents. Residents who are	09/04/2011

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	wheelchair to reclining chair. The resident was observed to be unsteady and unable to stand without complete assistance from C.N.A. #12. The resident's lower extremities appeared weak, with the resident unable to bear most of her own weight. The resident swayed from side to side, with her knees bent, while the C.N.A. transferred the resident. In an interview on 8/5/11 at 9:30 A.M., C.N.A. #11 indicated she had been caring for Resident #2 since May 2011, and the resident had never been independent with walking, and required complete assistance with transferring. She indicated the resident was alert; however orientation to person, place, and time was questionable each day. The clinical record for Resident #2 was reviewed on 8/2/11 at 10:50 A.M.. Diagnoses included, but were not limited to, rheumatoid arthritis, coronary artery disease, valvular heart disease, osteoporosis, hypertension, and history of urinary tract infections. The M.D.S. [Minimum Data Set] assessment dated 6/14/11 indicated the resident had a BIMS [Brief Interview for Mental Status] score of "13" [a score of 13-15=cognitively intact]. The resident		identified as a fall risk according to their most current assessment (admission or monthly assessment) careplan will be updated to include staff to be present with resident when in bathroom or bathroom door to be left slightly open when resident is in bathroom so staff can provide adequate supervision. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Nursing staff will be re-educated on the campus guideline for Falls Management Program. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Per the campus guidelines, the interdisciplinary team (IDT) will review the initiated falls circumstance and reassessment form (comprehensive assessment) in the daily clinical meeting 5 days a week, ongoing. The review is to ensure the thoroughness of the investigation, circumstance of the incident, reassessment accuracy and approach / intervention response. Additional information or changes to the approach / intervention will be noted on the falls circumstance and reassessment form during the IDT review. During the daily clinical review of the falls circumstance and reassessment forms, the IDT will ensure that if a	

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	was also identified as requiring extensive physical assistance of 1 staff person for transfers, dressing, toileting, and hygiene. "Ambulation" was indicated as "not performed by the resident or staff at all." A "Social Service Notes" dated 6/25/10 indicated "Admission note-Res [Resident] has fallen 13 times in the past year....Res utilizes w/c [wheelchair] and walker for ambulation..." A "Nurse's Notes" dated 11/24/10 at 7:00 P.M. indicated "C.N.A. reported res. fell on floor in bathroom.... Complains of right hip and knee pain.... lost her balance causing her to fall...." A "Nurse's Notes" dated 11/24/10 at 8:30 P.M. indicated "Report received from hospital. Res. positive for right hip fracture and will be admitted to hospital...." A "Physical Therapy Daily Note" dated 2/21/11 indicated "Withheld [therapy] secondary to increased pain from falling last night and breaking her right wrist.... Patient had a recent set-back in therapy secondary to fall during the night of 2/20/11...." A "Physical Therapy Discharge Summary" dated 3/15/11, indicated Resident #2 was "high fall risk." A "Fall Circumstance Investigation" dated 6/15/11, indicated Resident #2 fell at 8:25		resident is a fall risk, that it is added to the careplan and communicated to the staff that the staff is to be present with resident when in bathroom or bathroom door to be left slightly open when resident is in bathroom so staff can provide adequate supervision. The results of the audit/review will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter.	

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	A.M. in the restroom. The "IDT [Interdisciplinary Team] Review" note indicated to add as a "Prevention Update" intervention to the resident's Care Plan: "Do not leave res unattended in the restroom." A "Fall Circumstance Investigation" dated 6/25/11, indicated Resident #2 fell at 7:45 A.M. in the restroom. The description of the fall indicated "Res told C.N.A. to step out while I go to the bathroom. Res stood up and fell. C.N.A. right outside bathroom door." The "IDT Review" indicated to include "Staff must stay in restroom while res toilets." On 8/3/11, L.P.N. #6 provided the "Resident Care Sheet" forms. In an interview, she indicated the forms were used to communicate with the C.N.A.s about each resident's care. The "Special Needs" area of the "Resident Care Sheet" for Resident #2 listed an intervention added on 6/15/11 of "must stay in bathroom during toileting." The "Further Preferences" included, but were not limited to, "do not leave unassisted in bathroom..." On 8/4/11, the Divisional Clinical Support Registered Nurse for Trilogy Health Services, LLC, provided documentation of Resident #2's fall history. The			

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	documentation included a paper titled "Fall Timeline." The "Fall Timeline" for Resident #2 included the following dates for falls and interventions: Falls in the bathroom: 7/12/2010, 7/16/2010, 10/18/2010, 11/4/2010, 11/24/2010 [fractured hip], 2/21/11 [fractured wrist], 4/10/11, 6/15/11 [intervention to not leave alone in the bathroom], and 6/25/11 [Nurse's note stating C.N.A. left alone per resident's request.] Other falls: 8/19/2010, 8/31/2010, 10/6/2010, 10/8/2010, 1/11/2011, 2/3/2011, 4/10/2011, 7/1/2011, 7/9/2011, and 7/28/2011. Interventions put in place from 7/12 to 11/24/10: Removal of bath mat, bed alarm, encourage bath mat, provide chair in bathroom for grooming. There were no new interventions put into place following the fall with fracture on 11/24/10 except to "continue antibiotic for urinary tract infection." A sensor alarm to the wheelchair was added on 2/3/11. No new interventions were added after the			

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	fall with a wrist fracture on 2/21/11. On 4/10/11, an intervention was added to "continue to educate family and resident on safety concerns as family and resident request resident to be left alone in the bathroom." On 6/15/11, an intervention was added to "encourage resident to ask for assistance and not to be left unattended in the bathroom." On 6/25/11, the intervention included "resident and family encouraged that staff needs to stay in bathroom with resident due to resident not using call light to ask for assist. Resident and family agree to intervention." In an interview on 8/4/11 at 2:45 P.M., the Divisional Clinical Support Registered Nurse and the Director of Nursing indicated that leaving the resident in the bathroom upon her request was a resident's right regardless of her fall outcome. A "Falls Management Program Guidelines," dated as revised 3/08, included, but was not limited to, the following information: "PURPOSE: Trilogy Health Services			

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	(THS) strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures.... DEFINITION: A fall without injury is still a fall.... PROCEDURE: Should the resident experience a fall....a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions...." 3.1-45(a)(2)			

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F0356 SS=C	The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, there was no posting of nursing staff in the Legacy building and the posting for the nursing staff in the main building did not indicate the name of the facility on the posting. This had the potential to affect all 52 skilled bed residents and 8 dually certified bed residents.	F0356	**F 356It is the practice of this provider to post the nurse staffing data on a daily basis. However, in response to the findings of the 2567, the following measures and corrective actions have been taken: Corrective actions accomplished for those**	09/04/2011

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	Findings include: On 8/2/11 at 10:00 A.M., during the environmental tour with the Director of Plant Operations and the Director of Environmental Services, the posting for nursing staffing was found without the name of the facility printed on it. In the Legacy building, there was no posting of the nursing staffing found. In an interview with the Administrator on 8/4/11 at 2:45 P.M. he indicated that they do not have a posting for the nursing staffing in the Legacy building. 3.1-13(g)		**residents found to be affected by the alleged deficient practice:** The nurse staffing information is posted on a daily basis in the Health Campus and in the Legacy Campus. The campus name was added to the form used for the nurse staffing information posting. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The nurse staffing information is posted on a daily basis in the Health Campus and in the Legacy Campus. The campus name was added to the form used for the nurse staffing information posting. The designee responsible for the posting of the nurse staffing hours was educated on the requirement that the campus name must be posted on the daily nurse staffing information sheet and that the posting must also be located in the Legacy Campus as well as the Health Center Campus. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The ED or designee will observe that the nurse	

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			staffing hours are posted in both the Health Campus and the Legacy Campus. Will also observe that the campus name is listed on each posting. This audit will occur weekly times 4 weeks, then monthly times 5 months to ensure compliance. The audits will then be conducted randomly as need thereafter. The results of the audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter.	
F0371 SS=C	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure sanitary conditions of 1 of 4 food refrigerators which serves 52 residents in the main building of the facility. Findings include: During the kitchen tour with the Director of Food Services on 8/1/11 at 10:28 A.M. in the Mudstock Cafe which serves 52 residents, the refrigerator was found to have sticky food matter in the bottom of the refrigerator and crumbs of food particles stuck to the bottom of the refrigerator. The freezer had a large	F0371	**F 371** **It is the practice of this provider ensure that food is stored in sanitary conditions. However, in response to the findings of the 2567, the following measures and corrective actions have been taken:** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** The refrigerator and freezer were immediately cleaned and	09/04/2011

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PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BOULEVARD EA NOBLESVILLE, IN46060

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	puddle of purple frozen matter on the bottom of the freezer portion of the refrigerator. The Director of Food Services indicated he has a weekly cleaning schedule which the kitchen staff are in charge of performing. He stated that the sticky matter at the bottom of the refrigerator looked like juice and that the purple puddle was likely to be ice cream. He stated he was embarrassed and felt that it had not been cleaned in a while. 3.1-21(i)(3)		sanitized.**Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Dietary staff will be re-educated on the campus guideline and the cleaning schedules for refrigerators and freezers to ensure sanitary food storage conditions. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The Director of Food Services will audit and inspect the completion of the cleaning schedule of the refrigerator and freezers weekly for four weeks and monthly for five weeks and at least quarterly thereafter. Results of the cleaning schedule audits will be reported to the Governing Quality Assurance committee monthly for one (1) quarter and quarterly thereafter.	

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F0425 SS=C	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation and interview, the facility failed to ensure storage of only medications in the medication refrigerator on the Pioneer hall. This affected 1 of 2 medication refrigerators and had the potential to affect 52 residents who receive their medications out of this refrigerator. Findings include: During an observation of the Pioneer hall medication refrigerator with L.P.N. #5 on 8/2/11 at 1:05 P.M. the following items were found: one 20 ounce bottle of Fanta, one 20 ounce bottle of Coke Zero, one 12 ounce can of Diet Coke, one 8 ounce can of ginger ale, and one packet of liquid	F0425	**F 425It is the practice of this provider ensure that only medication is stored in the medication refrigerators. However, in response to the findings of the 2567, the following measures and corrective actions have been taken: Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** All non-medication items were removed from the refrigerator in the medication room on Pioneer Hall. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: The refrigerators for the other 2	09/04/2011

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	coffee creamer. In an interview at 2:07 P.M. on 8/2/11, L.P.N. #5 indicated that the residents drinks should be labeled with their initials that are kept in the medication refrigerator. In regards to the liquid coffee creamer, she indicated that these items are not usually kept in this refrigerator. In an interview during the daily conference on 8/3/11 at 3:45 P.M., the Divisional Clinical Support Registered Nurse indicated personal food items should not be kept in the medication refrigerators, but that the facility did not have a written policy/procedure addressing this. 3.1-25(m)		hallways (Noble and Conner) were observed to ensure that there were no non-medication items being stored in the medication room refrigerators. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Licensed staff will be re-educated on the campus guideline for Medication Storage in the Facility. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The DHS or designee will observe the refrigerators located in the medication rooms on Connor, Noble and Pioneer Halls to ensure that there is storage of medications only. This observation will occur 3 times per week times 4 weeks, then monthly times 5 months to ensure compliance. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter.	
F9999	STATE FINDINGS 1.) 3.1-9 PERSONAL PROPERTY (g) The facility must inventory, upon admission and discharge, the personal effects, money, and valuables declared by	F9999	**F9999** **It is the practice of this provider to inventory, upon admission and discharge, the personal effects, money, and valuables declared by the resident at the time of admission. However, in**	09/04/2011

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	the resident at the time of admission. It is the resident's responsibility to maintain and update the inventory listing of the resident's personal property. THIS STATE RULE WAS NOT MET AS EVIDENCED BY: Based record review and interview, the facility failed to have personal inventory sheets completed for 2 of 2 closed records reviewed in a sample of 15. [Resident #150 and Resident #151] Findings include: The closed records for Resident #150 and Resident #151 were reviewed on 8/4/11. Personal inventory sheets were not found for either resident. In an interview on 8/5/11 at 10:00 A.M., Trilogy Divisional Clinical Support Registered Nurse indicated she could not locate personal inventory sheets for either resident. She indicated she was aware a personal inventory needed to be completed for each resident. 3.1-9(g) 2.) 3.1-36 DISCHARGE SUMMARY		**response to the findings of the 2567, the following measures and corrective actions have been taken:** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Closed record review: Residents #150 and #151 have been discharged **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All resident's have the potential to be affected by this same deficient practice. Will complete an audit of current residents in the campus to ensure the personal inventory sheet is complete. Any inventory sheets found to be incomplete will be updated with current information. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Nursing staff will be educated on the state regulation for inventory of personal property. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** DHS or designee will audit personal inventory sheets of 3 discharges and / or new	

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	(a) When the facility anticipates discharge, a resident must have a discharge summary that includes the following: (2) A final summary of the resident's status to include the components of the comprehensive assessment, at the time of the discharge that is available for release to authorized persons and agencies with the consent of the resident or legal representative. THIS STATE RULE WAS NOT MET AS EVIDENCED BY: Based on clinical record review and interview, the facility failed to have the discharge summary for 1 of 2 closed records reviewed in a sample of 15. [Resident #150] Findings include: The closed record for Resident #150 was reviewed on 8/4/11. A discharge summary was not present in the closed record for Resident #150. In an interview on 8/5/11 at 10:00 A.M., Trilogy Divisional Clinical Support Registered Nurse indicated she could not locate a discharge summary for Resident #150. She indicated she was aware that a		admissions to ensure they are complete. The audit will occur 3 times per week times 4 weeks, then monthly times 5 months to ensure compliance. The results of the audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter. **F 9999** **It is the practice of this provider to have a discharge summary and a final summary of the resident's status at the time of discharge. However, in response to the findings of the 2567, the following measures and corrective actions have been taken:** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Closed record review: Resident #150 has been discharged. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All discharged residents have the potential to be affected by this same alleged deficient practice.	

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	discharge summary was required for each resident. 3.1-36(a)(2) 3.) 3.1-50 CLINICAL RECORDS (i) Current clinical records shall be completed promptly and those of discharged residents shall be completed within seventy (70) days of the discharge date. THIS STATE RULE WAS NOT MET AS EVIDENCED BY: Based on record review and interview, the facility failed to complete the closed clinical record for 1 of 2 residents reviewed who were discharged more than 70 days prior to the survey date of 8/5/11, in a sample of 15 residents. [Resident #150] Findings include: The record for Resident #150 was reviewed on 8/4/11. The resident was discharged from the facility on 5/6/11. Resident #150's clinical record was not complete within 70 days. There was no discharge order for home and the		**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Licensed staff will be re-educated on the campus guideline for Discharge Instructions. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The DHS or designee will audit / review the discharge summary of 3 resident discharges to ensure it is complete. The audit will occur 3 times per week times 4 weeks, then monthly times 5 months to ensure compliance. The results of the audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter. **F 9999** **It is the practice of this provider ensure that the clinical records of discharged residents are completed within seventy days of the discharge date. However, in response to the findings of the 2567, the following measures and corrective actions have been taken:** **Corrective actions**	

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	discharge summary was not present. In an interview on 8/5/11 at 1000 A.M., Trilogy Divisional Clinical Support Registered Nurse indicated she could not locate a discharge order from the physician or the discharge summary. She indicated she was aware that clinical records were required to be complete in 70 days from discharge. 3.1-50(i)		**accomplished for those residents found to be affected by the alleged deficient practice:** Closed record review: Resident #150 was discharged on 5/6/11. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All discharged residents have the potential to be affected by this same alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Licensed staff will be re-educated on the campus guideline for Discharge Instructions and the need for a discharge order prior to the resident being discharged from the campus. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The DHS or designee will audit / review the discharge summary of 3 resident discharges to ensure it is complete and ensure a discharge order is present. The audit will occur 3 times per week times 4 weeks, then monthly times 5 months to ensure compliance. The results of the audits will be reported, reviewed and trended	

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			for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter.	
R0000				
	The following Residential deficiencies were cited in accordance with 410 IAC 16.2-5.	R0000	Prairie Lakes Health Campus submits this plan of correction in response to the state requirement deficiencies cited during the Recertification and State Licensure Survey conducted on August 5, 2011 **Please accept this plan of correction as the providers letter of credible allegation of compliance effective September 4, 2011.**	

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R0090	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a			

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	notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observation and interview, the facility failed to post a notice of the availability of the most recent survey results in the 2 of 2 buildings of the facility. This had the potential to affect all residential residents of the facility. Findings include: During the completion of the environmental tour on 8/2/11 at 10:45 A.M. the posting of where the survey was located was unable to be found. In an interview with the Administrator on 8/4/11 at 3:45 P.M. he indicated that they do not have signs posted indicating where the survey book can be located either in the Legacy building or the main building of the facility.	R0090	**R 090 It is the practice of this provider to make the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect readily available for our residents to examine. However, in response to the findings of the 2567, the following measures and corrective actions have been taken: Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** A sign will be posted in the main skilled health care campus and in the Legacy campus indicating where the results of the most current annual survey and any subsequent surveys are located.**Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents living in the health campus and the Legacy campus have the potential to be affected by this alleged deficient practice.**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** During	09/04/2011

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			the next resident counsel meeting, the location of where they can view the survey results will be reviewed with the residents in attendance. A sign will be posted in the main skilled health care campus and in the Legacy campus indicating where the results of the most current annual survey and any subsequent surveys are located.**How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The ED or designee will observe that the sign posting for the location of the survey results remains in place. This audit will occur monthly times 6 months to ensure compliance. The audits will then be conducted randomly as need thereafter. The results of the audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter.	
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to complete preadmission evaluations for 5 of 7 sampled residential residents prior to their admission to the	R0214	**R 214** **It is the practice of this provider to complete a preadmission evaluation on**	09/04/2011

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	facility. (Residents #65, #91, #105, #109, and #152) Findings include: 1. Record review for Resident #65 was done on 8/1/11 at 1:15 P.M. diagnoses included, but were not limited to, dementia, unsteady gait, and high blood pressure. The resident was admitted on 10/24/10. No pre-admission evaluation information was found. A request for the pre-admission evaluation information was given to the DHS (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M. 2. Record review for Resident #91 was done on 8/3/3/11 at 10:20 A.M. Diagnoses included, but were not limited to, dementia, gait instability, and history of deep vein thrombosis. The resident was admitted on 3/3/11. No pre-admission evaluation information was found. 3. Record review for Resident #105 was done on 8/2/11 at 1:50 P.M. Diagnoses included, but were not limited to, anemia, dementia, high blood pressure, and renal insufficiency. The resident was admitted on 10/28/10. No pre-admission evaluation information was found.		**each resident prior to their admission to our campus. However, in response to the findings of the 2567, the following measures and corrective actions have been taken:** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident's #65, 91, 105 and 109 remain resident's of campus. Resident #152 has been discharged. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents admitted have the potential to be affected by this same deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The admission team will be educated on the campus guideline for Preadmission Evaluation. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The DHS or designee will review all preadmission evaluations to ensure they are completed prior to the resident's admission to the campus. This review will be ongoing.	

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	A request for the preadmission evaluation information was given to the DHS (Director of Health Services) regarding Resident #105 at the daily conference on 8/3/11 at 4:00 P.M. 4. Record review for Resident #109 was done on 8/2/11 at 1:15 P.M. Diagnoses included, but were not limited to, dementia with depression and high blood pressure. The resident was admitted on 3/30/11. No pre-admission evaluation information was found. A request for the preadmission evaluation information was given to the DHS (Director of Health Services) regarding Resident # 109 at the daily conference on 8/3/11 at 4:00 P.M. 5. In an interview on 8/4/11 at 11:15 A.M., the Director of Clinical Services indicated she was not able to locate any preadmission evaluations for Resident # 65, 91, 105, and 109. 6. The clinical record for Resident # 152 was reviewed on 8/4/11. Diagnoses included, but were not limited to, hypertension, paranoia, and tremors. The "Pre-Admission Evaluation" was not located in Resident # 152's clinical record.		The results of the audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter.	

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	155779	A. BUILDING 00 B. WING	08/05/2011

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	In an interview on 8/5/11 at 1000 a.m., Trilogy Divisional Clinical Support Registered Nurse indicated she could not locate a "Pre-Admission Evaluation." She was aware a Pre-Admission Evaluation needed to be completed for all residents.			
R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to address services to be	R0217	**R 217**	09/04/2011

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	provided to 1 of 1 resident receiving an anticoagulant medication; have the service plan signed by 4 of 4 residents or a designated representative; or complete a service plan for 1 resident. This deficiency impacted 5 residents in a residential sample of 7 residents reviewed. [Residents #65, #91, #105, #109, and #152] Findings include: 1. Record review for Resident #91 was done on 8/3/11 at 10:20 A.M. Diagnoses included, but were not limited to, gait instability, dementia and history of deep vein thrombosis. The physician orders recapitulation sheet indicated the resident received Coumadin 2.5 mg. [milligrams] daily, ordered on 6/17/11. The current service plan had an initial date of 3/3/11, with revisions on 6/2/11 and 7/12/11. Services to be provided [i.e. monitoring for bleeding, preventative measures, etc.] were not listed. The resident was sent to the emergency room on 6/30/11 for a laceration on her head from a fall. In an interview during the daily		**It is the practice of this provider to complete an evaluation on each resident addressing the services to be provided. In addition, the service plan is to be signed by the resident or a designated representative. However, in response to the findings of the 2567, the following measures and corrective actions have been taken:** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #91 service plan was updated to include monitoring of bleeding related to Coumadin use. Resident #65, 105 and 109 service plans were updated, reviewed with resident and / or responsible party and signature was obtained on the service plan. Resident #152 discharged. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Service plans for current residents will be reviewed to ensure the service plan is complete, the services provided are addressed and that the service plan has been reviewed with the resident and / or responsible party and a signature	

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	conference on 8/4/11 at 2:45 P.M., the Director of Health Services indicated that bleeding precautions for a resident who is on Coumadin should be included in a service plan. 2. Record review for Resident #65 was done on 8/1/11 at 1:15 P.M. Diagnoses included, but were not limited to, dementia, unsteady gait, and high blood pressure. The most recent service plan was dated 5/13/11. There was no resident or responsible part signature under the portion of the document titled "signature and date of service plan team (includes resident and/or responsible party)." In an interview on 8/4/11 at 2:45 P.M., the Administrator indicated there should be a signature from the resident or the family member on the service plan. 3. Record review for Resident #105 was done on 8/2/11 at 1:50 P.M. Diagnoses included, but were not limited to, dementia, renal insufficiency and anemia. Service plans were dated 1/19/11, 4/17/11, and 7/8/11. There was no resident or responsible part signature under the portion of the document titled "signature and date of service plan team (includes		is obtained on the service plan. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Licensed staff and Legacy Lane Director will be re-educated on the campus guidelines for Evaluation and Service Plan. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The DHS or designee will audit 5 service plans to ensure they are complete, the services being provided are addressed and that the service plan has been reviewed with the resident and / or responsible party and a signature is obtained on the service plan. This audit will occur 3 times per week times 4 weeks, then monthly times 5 months to ensure compliance. The results of the audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter.	

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	resident and/or responsible party)" on any of the service plans. In an interview with the administrator on 8/4/11 at 2:45 P.M., he indicated that the resident or family member should sign the service plan. 4. Record review for Resident #109 was done on 8/3/11 at 1:15 P.M. Diagnoses included, but were not limited to, dementia with depressions, and high blood pressure. The current service plan had an original date of 3/30/11 with a revision date of 7/8/11. There was no resident or responsible part signature under the portion of the document titled "signature and date of service plan team (includes resident and/or responsible party)." In an interview with the administrator on 8/4/11 at 2:45 P.M., he indicated that the resident or family member should sign the service plan. 5. The closed clinical record for Resident # 152 was reviewed on 8/4/11. Diagnoses included, but were not limited to, hypertension, paranoia, and tremors. The "Service Plan" was not located in Resident # 152's clinical record.			

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	In an interview on 8/5/11 at 10:00 A.M., Trilogy Divisional Clinical Support Registered Nurse indicated she could not locate a Service Plan for this resident. She was aware a Service Plan needed to be completed for all residents.			
R0410	(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to obtain a first step tuberculin skin test on/or prior to admission, or a subsequent second step within 1-3 weeks following a negative first step skin test, for 2 of 2 residents, in a sample of 7 Residential-licensed reviews. [Resident #109 and 152]	R0410	**R 410 It is the practice of this provider to obtain a first step tuberculin skin test on/or prior to admission, or a subsequent second step within 1-3 weeks following a negative first step skin test. However, in response to the findings of the 2567, the following measures and corrective actions have**	09/04/2011

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	Findings include: 1. The clinical record for Resident # 152 was reviewed on 8/4/11. Diagnoses included, but were not limited to, hypertension, paranoia, and tremors. First and second step tuberculin skin tests were not located in the resident's clinical record. In an interview on 8/5/11 at 10:00 A.M., Trilogy Divisional Clinical Support Registered Nurse indicated she could not locate any documentation of a first and second step tuberculin skin test for this resident. She indicated she was aware the tuberculin skin tests were required to be completed for all residents.		**been taken: Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #109 has a current tuberculin skin test documented. Resident #152 has been discharged. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Audit will be completed on all current residential residents to ensure a current tuberculin skin test is documented. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Licensed staff will be re-educated on the campus guideline for TB Screening of Residents and the Program Components. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** DHS or designee will audit 3 new admissions to ensure the campus obtained a first step tuberculin skin test on/or prior to admission, or a subsequent second step within 1-3 weeks follo9wing a negative first step skin test. The audit will occur 3 times per week times 4 weeks, then monthly times 5 months to ensure compliance. The results of the audits will be reported, reviewed and trended for compliance thru the campus	

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	2. Record review for Resident #109 was done on 8/3/11 at 1:15 P.M. Diagnoses included, but were not limited to dementia and high blood pressure. Resident #109 was admitted on 4/30/11. A tuberculosis (TB) skin test done prior to, or at the time of, admission was not found. A request for TB skin test documentation was given to the Director of Health Services on 8/3/11 at 3:45 P.M. the daily conference. In an interview with the Clinical Services Coordinator on 8/4/11 at 11:15 A.M. she indicated that she could not locate the TB documentation.		Quality Assurance Committee for a minimum of 6 months then randomly thereafter.	